

APPLICATION FOR ELAN BENEFIT PROGRAM

**TO BE
 COMPLETED
 BY PROPOSED
 INSURED**

**PLEASE
 ANSWER ALL
 QUESTIONS**

Proposed Insured:		Citizenship:	
Canadian Address:			
Out of Country Address:			
Date of Birth	Day/Month/Year	Sex:	Height:
Weight:			
Profession or Occupation:			
Nature of duties:			
Annual Salary:			
Beneficiary:			
Social Insurance No:		Provincial Government Health Card No:	
Employer's Name:			
Employer's Address:			
Is this benefit taxable to the Insured Person?		<input type="checkbox"/> no	<input type="checkbox"/> yes
Broker/Agent/Consultant:			
Contact name and telephone no:			
Are you now, and have you been, in sound health for one year preceding this application?		<input type="checkbox"/> yes	<input type="checkbox"/> no/describe nature of impairment
Have you consulted a doctor during the past two years?		<input type="checkbox"/> no	<input type="checkbox"/> yes/state date, reason and name and address of Physician
Have you, to your knowledge, during the past twenty-one days, been exposed to any infections or contagious disease?		<input type="checkbox"/> no	<input type="checkbox"/> yes/describe in detail
Do you intend to travel outside Canada or the U.S.A. during the next twelve months?		<input type="checkbox"/> no	<input type="checkbox"/> yes/state countries to be visited, length of stay, purpose
Within the past ten years have you consulted a physician, or had treatment or surgery, or taken prescribed medication, for a sickness or injury arising from any of the following: If YES, please describe in detail including dates and prognosis.			
High blood pressure, chest pain or disorder of the heart or circulatory system?		<input type="checkbox"/> no	<input type="checkbox"/> yes
Diabetes, cancer, tumor or disorder of the glands, bone, blood or skin?		<input type="checkbox"/> no	<input type="checkbox"/> yes

**BROKER
 INFORMATION**

Disorder of the breasts, reproductive organs, kidneys or urinary system?	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Hernia, or disorder of the liver, gall bladder, stomach, intestines or rectum?	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Arthritis, rheumatism, or disorder of the limbs, back, neck or spine?	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Neuritis, sciatica, gout or any disorder of the muscles, bones or joints?	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Allergy, asthma, sinusitis, emphysema, or disorder of the lungs?	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, tuberculosis or chronic respiratory disorder?	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Epilepsy, stroke, dizziness, or disorder of the brain or spinal cord?	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Emotional, mental or nervous disorder?	<input type="checkbox"/> no	<input type="checkbox"/> yes		
Any change of weight in the past year?	<input type="checkbox"/> no	<input type="checkbox"/> yes		
FEMALES ONLY	Have you ever had any disorder of menstruation, of pregnancy or of the female organs or breasts?	<input type="checkbox"/> no <input type="checkbox"/> yes		
	To the best of your knowledge and belief are you now pregnant?	<input type="checkbox"/> no <input type="checkbox"/> yes		
FAMILY HISTORY	Is there, in your family, any history of diabetes, cancer, high blood pressure, heart disease, or mental illness or suicide?	<input type="checkbox"/> no <input type="checkbox"/> yes		
		Age if Living	Age at Death	State of Health or Cause of Death
	Father			
	Mother			
	Brothers & sisters No. living [] No. dead []			

HAVE YOU EVER: If yes, please describe in detail:

Smoked any tobacco products in the past twelve months?	<input type="checkbox"/> no	<input type="checkbox"/> yes
Required treatment for the use of alcohol or drugs, or used either to excess?	<input type="checkbox"/> no	<input type="checkbox"/> yes
Used cocaine, narcotics, marijuana or any other habit forming drug?	<input type="checkbox"/> no	<input type="checkbox"/> yes
Have you ever had your drivers license revoked for any period of time, for driving while under the influence of alcohol?	<input type="checkbox"/> no	<input type="checkbox"/> yes
To the best of your knowledge, have you ever been treated for, or told you had, AIDS (Acquired Immune Deficiency Syndrome), ARC (Aids Related Complex) or any other immunological disorder?	<input type="checkbox"/> no	<input type="checkbox"/> yes
Do you have an amputation of any kind, or any physical deformity, impairment or handicap?	<input type="checkbox"/> no	<input type="checkbox"/> yes
During the past five years have you undergone any surgical operation(s)?	<input type="checkbox"/> no	<input type="checkbox"/> yes/state month/date/year, reason, physician's name and address
Have you any reason to think that you may need to undergo a surgical operation in the future?	<input type="checkbox"/> no	<input type="checkbox"/> yes/approximate date for surgery, reason for surgery
Do you have insurance similar to that now being applied for?	<input type="checkbox"/> no	<input type="checkbox"/> yes/name of insurer, policy benefit(s)
In the event of accident or illness, would the applicant be eligible for reimbursement under any Canadian, Provincial or Federal Government Health Plan?	<input type="checkbox"/> no	<input type="checkbox"/> yes
Have you made any claim(s) against an insurer in respect of an accident or illness?	<input type="checkbox"/> no	<input type="checkbox"/> yes/date & nature of claim, amount of claim
Have you ever been declined, or accepted on special terms, for Life Insurance or Accident and Health Insurance?	<input type="checkbox"/> no	<input type="checkbox"/> yes
Has any Life, or Accident and Health Insurer, ever cancelled or declined to renew your coverage?	<input type="checkbox"/> no	<input type="checkbox"/> yes/month/year of action, reason for action
Have you an application pending for any other Accident or Sickness Insurance?	<input type="checkbox"/> no	<input type="checkbox"/> yes/date of application, name of Insurer, benefit(s) applied for
Do you scuba dive, or race motorcycles or boats?	<input type="checkbox"/> no	<input type="checkbox"/> yes

Do you engage in other hazardous activities not shown above? <input type="checkbox"/> no	<input type="checkbox"/> yes/nature of activity, extent and frequency of participation
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If you use a motor vehicle in connection with your business or occupation, give your approximate annual mileage if this will exceed 18,000 miles/30,000 km (business and pleasure) _____ or N/A

You may elect Major Medical coverage for your spouse and dependents who are stationed with you outside the country. If you choose this option, please complete the following section:

Name	Date of Birth	Relationship
Have any of the named individuals been hospitalized in the past 24 months? <input type="checkbox"/> no	<input type="checkbox"/> yes, please provide details	
Are any of the named individuals currently taking medication or receiving medical treatment? <input type="checkbox"/> no	<input type="checkbox"/> yes, please provide details	

DECLARATION

I hereby warrant that the above statements are true and correct to the best of my knowledge and belief and, that I have not withheld any information which is calculated to influence the decision of the Insurer. I understand that non-disclosure or misrepresentation of a material fact will render this insurance null and void.

NOTE: A material fact is one likely to influence acceptance or assessment of this application by the Insurer. If you are in doubt as to what constitutes a material fact you should consult your agent, or WILLIAM J. SUTTON & CO. LTD.

I understand that signing this application does not bind me to complete the insurance but, I do agree that, should a Document of Insurance be concluded, this Application, and the statements made herein, shall form the basis of the Insurance. Further, that WILLIAM. J. SUTTON & CO. LTD. is hereby authorized as the sole representative for placement of this insurance.

Signature of Proposed Insured

Date

Applicant/Owner (corporation/partnership/trustee or individual other than Proposed Insured)

By (signature & title)

Witnessed, by Licensed resident agent

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me, or my health, to give WILLIAM J. SUTTON & CO. LTD. any such information. A photographic copy of this authorization shall be as valid as the original.

Signature of Proposed Insured

Date

Signed at